AGENDA ITEM NO:

UNIVERSITY HOSPITALS BIRMINGHAM NHS FOUNDATION TRUST
BOARD OF DIRECTORS
THURSDAY 26 JULY 2012

Title:	**QUALITY ACCOUNT UPDATE FOR Q1 2012/13**
Responsible Director:	David Rosser, Executive Medical Director
Contact:	Imogen Gray, Head of Quality Development, 13687

Purpose:	To present the Trust's Quality Account Update for Quarter 1 2012/13.
Confidentiality Level & Reason:	N/A
Annual Plan Ref:	Strategic Aim: To deliver and be recognised for the highest levels of quality of care through the use of technology, information, and benchmarking
Key Issues Summary:	• The Q1 2012/13 Quality Account Update is shown in Appendix A. • The latest SHMI is 101 which is as expected. The HSMR is outside the expected range (110.88) and included for completeness. • Performance for the Quality Improvement Priorities and selected indicators is generally strong. Performance for VTE prevention has remained the same and plans are in place to try to deliver an improvement by year end. • Performance for the specialty indicators will be included as an appendix to the update report before publication.
Recommendations:	The Board of Directors is asked to: **Approve** the content of the Quality Account Update for Quarter 1 2012/13 for external publication.

Signed:	**Date:** 17 July 2012

UNIVERSITY HOSPITALS BIRMINGHAM NHS FOUNDATION TRUST

BOARD OF DIRECTORS
THURSDAY 26 JULY 2012

QUALITY ACCOUNT UPDATE FOR QUARTER 1 2012/13

PRESENTED BY EXECUTIVE MEDICAL DIRECTOR

1. **Introduction**

The aim of this paper is to present the Trust's Quality Account Update for Q1 2012/13 prior to external publication in August 2012. The Trust's Quality Account Update report for April-June 2012 is shown in Appendix A following discussion at the Clinical Quality Monitoring Group (CQMG) in July 2012.

2. **Performance**

2.1 Mortality: SHMI and HSMR

The report contains the Trust's Summary Hospital-level Mortality Indicator (SHMI) figure for January-December 2011 which has been calculated by Health Informatics. The SHMI is within the expected range. The Health Informatics Team has calculated the Trust's Hospital Standardised Mortality Ratio (HSMR) value for 2011/12 is 110.88, as calculated by Health Informatics. This value is outside the expected range and is likely to be publicly available sometime in the Autumn. The HSMR has been included in the Quality Account Update for Q1 2012/13 simply for completeness with a statement explaining that the underlying methodology is largely discredited.

2.2 Quality Improvement Priorities

2.2.1 Performance for the five 2012/13 Quality Improvement Priorities and selected metrics is generally strong. Performance for VTE prevention remains about the same. The accuracy of completed VTE risk assessments and the rates of VTE prophylaxis are currently being reviewed by Dr Will Lester, Clinical Haematologist. The results are due to be presented to the September Clinical Quality Monitoring Group (CQMG) meeting by Dr Will Lester and Dr Jamie Coleman, Consultant in Clinical Pharmacology, for discussion. Plans will then be developed to try to improve performance by year end.

2.2.2 Patient feedback received through the telephone surveys has decreased during quarter 1 2012/13. A postal survey is due to be piloted during quarter 2 2012/13 and will be monitored by the associate Director for Corporate Affairs.

2.2.3 The Trust is continuing to see a higher proportion of harm incidents due to the increased reporting of pressure ulcers. As a result, there has been a reduction in the percentage of patient safety incidents which are no harm (indicator 4a) and an increased percentage resulting in severe harm (indicator 4b) in quarter 1 2012/13.

2.2.4 The admissions data used to calculate the following patient safety indicators has been revised to include dialysis patients which are classed as admissions. This has resulted in a reduced reporting rate overall and a lower percentage of falls.

3(a). Patient safety incidents (reporting rate per 100 admissions)
6. Falls (incidents reported as % of elective and emergency admissions)

3. Specialty Quality Indicators

Performance for the specialty indicators will be added at the end of the update report before publication but is not included here for brevity. There are no particular concerns over publication of this information. The draft QuORU (Quality and Outcomes Research Unit) Indicator Framework has been developed and is currently being reviewed by Deloitte, the Trust's Internal Auditor. A paper outlining the purpose of the framework and accompanying process will be submitted to the Chief Executive's Advisory Group for review and approval in August 2012.

4. Recommendations

The Board of Directors is asked to:

Approve the content of the Quality Account Update for Quarter 1 2012/13 for external publication.

Appendix A: Quality Account Update for April-June 2012

Contents

Quality Account Update for April-June 2012

1. Introduction

The Trust published its fourth Quality Account Report in June 2012 as part of the Annual Report and Accounts. The report contained an overview of the quality initiatives undertaken in 2011/12, performance data for selected metrics and set out five priorities for improvement during 2012/13:

Priority 1: Improving VTE Prevention
Priority 2: Improve patient experience and satisfaction
Priority 3: Electronic observation chart – completeness of observation sets (to produce an early warning score)
Priority 4: Reducing medication errors (missed doses)
Priority 5: Infection prevention and control

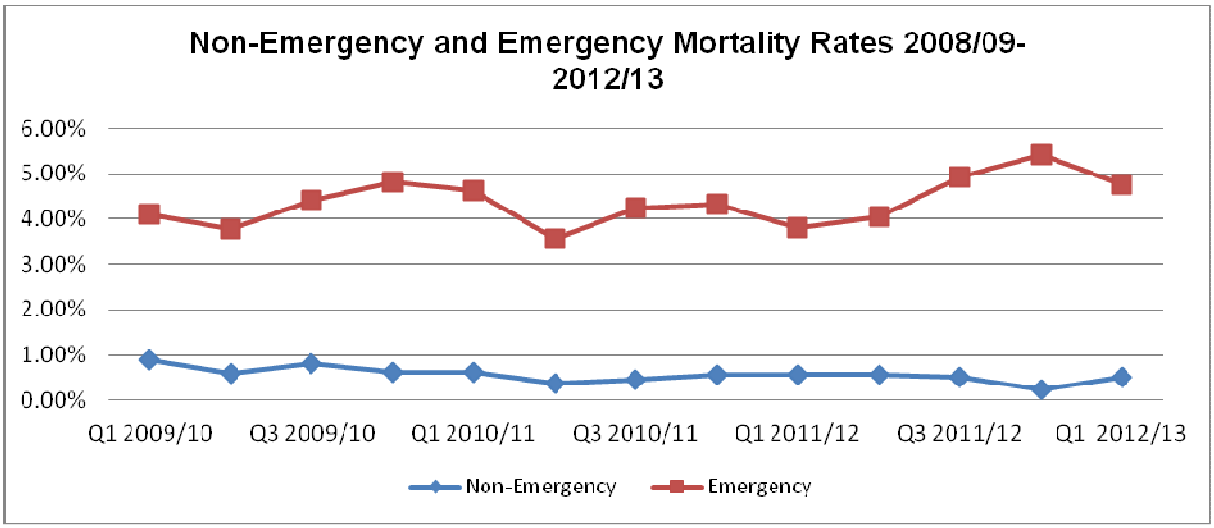
This report provides an update on the progress made for the period April-June 2012 towards meeting these priorities and updated performance data for the selected metrics. This update report should be read alongside the Trust's Quality Account Report for 2011/12.

2. Mortality

The Trust continues to monitor mortality as close to real-time as possible with senior managers receiving daily emails detailing mortality information and on a longer term comparative basis via the Trust's Clinical Quality Monitoring Group. Any anomalies or unexpected deaths are promptly investigated with thorough clinical engagement.

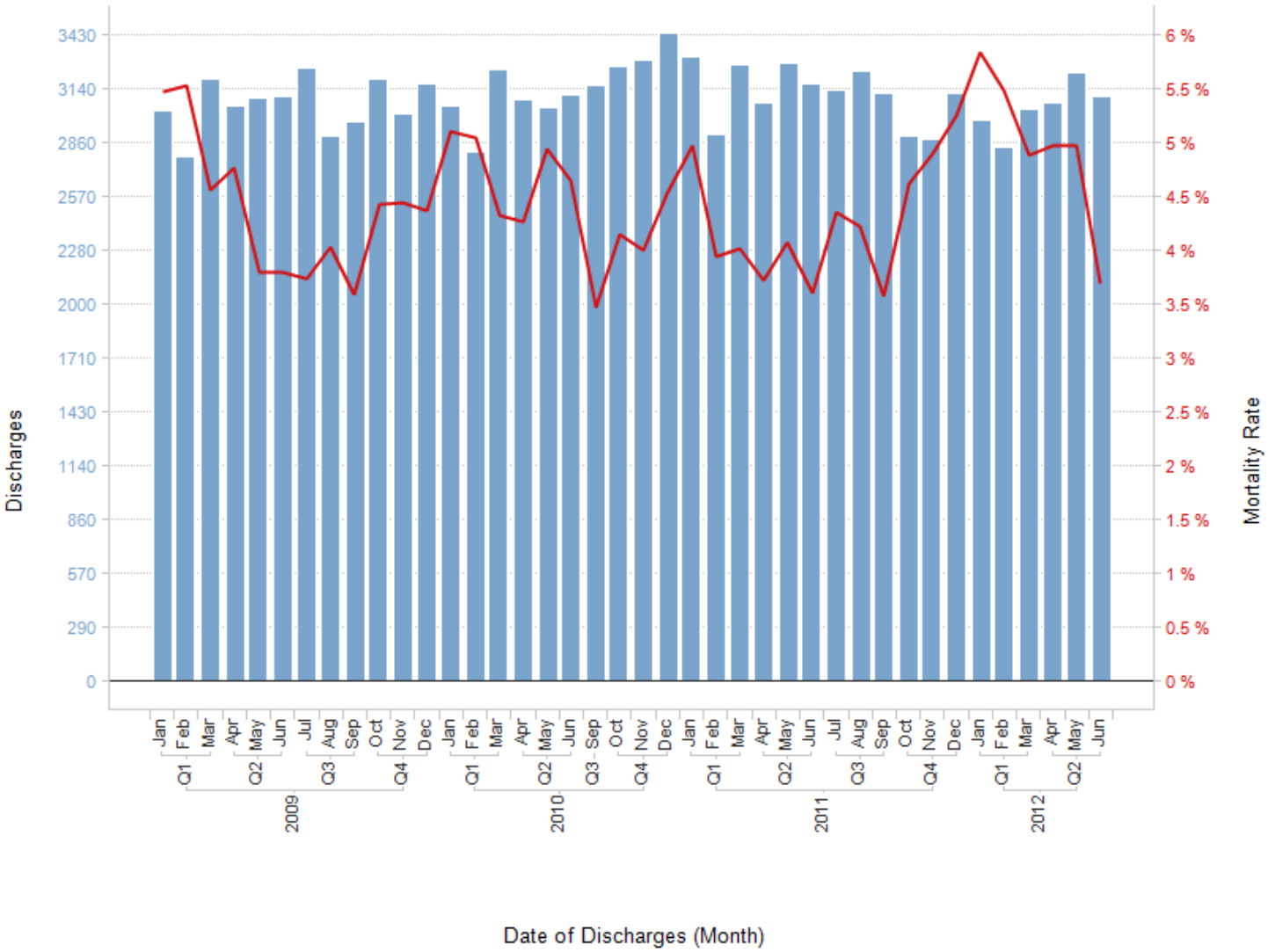
Emergency and Non-Emergency Mortality

The graph below shows the non-emergency and emergency mortality rates by quarter for the last three financial years. Although the Trust is generally treating more elderly patients and patients with complex conditions, mortality continues to remain stable. The Trust has not included comparative information due to concerns about the validity of single measures used to compare trusts.



Crude Mortality

The graph below shows the Trust's crude mortality rate against activity (patient discharges) by quarter for the past three calendar years:



Summary Hospital-level Mortality Indicator (SHMI)

In October 2011, the NHS Information Centre published data for the Summary Hospital-level Mortality Indicator. This is the new national hospital mortality indicator which replaces previous measures such as the Hospital Standardised Mortality Ratio (HSMR). The SHMI is a ratio of observed deaths in a trust over a period time divided by the expected number based on the characteristics of the patients treated by the trust. A key difference between the SHMI and previous measures is that it includes deaths which occur within 30 days of discharge, including those which occur outside hospital.

The new indicator should be interpreted with caution as no single measure can be used to identify whether hospitals are providing good or poor quality care. An average hospital will have a SHMI around 100; a SHMI greater than 100 implies more deaths occurred than predicted by the model. A higher than expected SHMI should be used as a trigger for further investigation. The NHS Information Centre will publish updated SHMI data on a quarterly basis and is expected to make refinements to the way the indicator is calculated over time.

The Trust's latest SHMI is 101 for the period January 2011-December 2011 which is within the expected range.

Although the Hospital Standardised Mortality Ratio (HSMR) has been superseded by the SHMI and the Trust has serious concerns about the validity of the HSMR, it is included here for completeness. UHB's overall 1 year HSMR value is 110.88 for 2011/12 which means it is outside the expected range. The validity and appropriateness of the HSMR methodology used to calculate the expected range has however been the subject of much national debate and is largely discredited[1][2]. The Trust is continuing to robustly monitor mortality in a variety of ways as detailed above.

3. Quality Improvement Priorities

Priority 1: Improving VTE Prevention

Venous thromboembolism (VTE) is the term used to describe deep vein thrombosis (blood clot occurring in a deep vein, most commonly in the legs) and pulmonary embolism (where such a clot travels in the blood and lodges in the lungs) which can cause considerable harm or death. VTE is associated with periods of immobility and can largely be prevented if appropriate preventative measures are taken.

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[1] Hogan H, Healey F, Neale G, Thomson R, Vincent C, Black, N. Preventable deaths due to problems in care in English acute hospitals: a retrospective case record review. BMJ Quality & Safety. Online First. 7 July 2012.

[2] Lilford R, Mohammed M, Spiegelhalter D, Thomson R. Use and misuse of process and outcome data in managing performance of acute and medical care: Avoiding institutional stigma. The Lancet. 3 April 2004.

Whilst many other trusts have to rely on a paper-based assessment of the risk of VTE for individual patients, the Trust has been using an electronic risk assessment tool within the Prescribing Information and Communication System since June 2008 for all inpatient admissions. The tool provides tailored advice regarding preventative treatment based on the assessed risk.

As the Trust has performed consistently highly for completion of VTE risk assessments in 2011/12, the focus of this priority will change to VTE prevention through appropriate administration of preventative (prophylactic) treatment during 2012/13. This includes graduated elastic compression stockings (GECS) and enoxaparin (medication used to reduce the risk of blood clots forming). The Trust will be focusing on improving compliance with the outcomes of completed VTE risk assessments so that a higher percentage of patients receive the preventative treatment they require, particularly pharmacological treatment (Enoxaparin medication).

During 2011/12, the Trust started to regularly monitor whether patients are given VTE prevention treatment, if required, following risk assessment. Performance for individual wards and the Trust overall is now available on the electronic Clinical Dashboard to allow real-time audit of performance by nursing and medical staff.

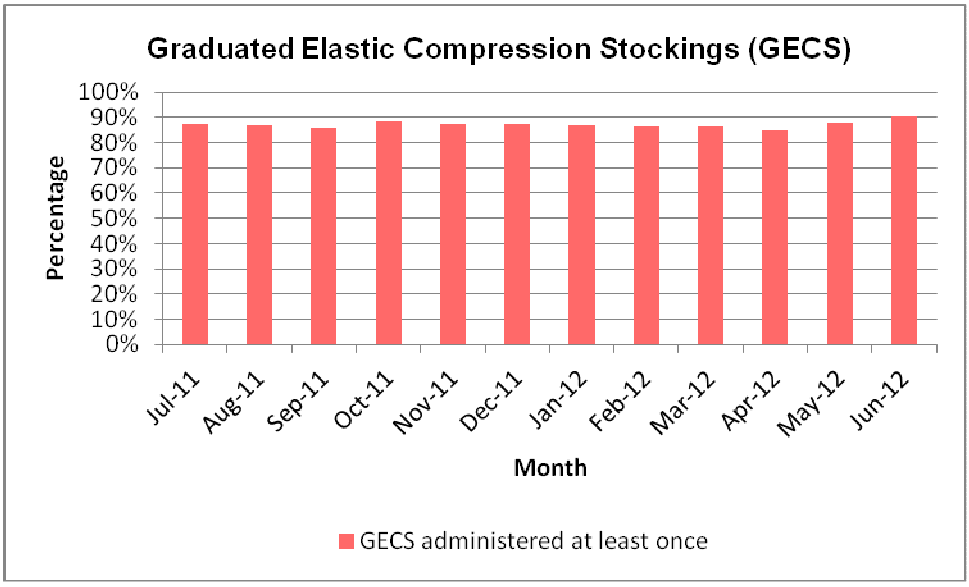
Performance

VTE Risk Assessment Completion

The Trust has achieved a VTE risk assessment completion rate of at least 98% since September 2010. This is well above the national average of 93% for NHS acute providers as published on the Department of Health website (January to March 2012).

VTE Prevention – Graduated Elastic Compression Stockings

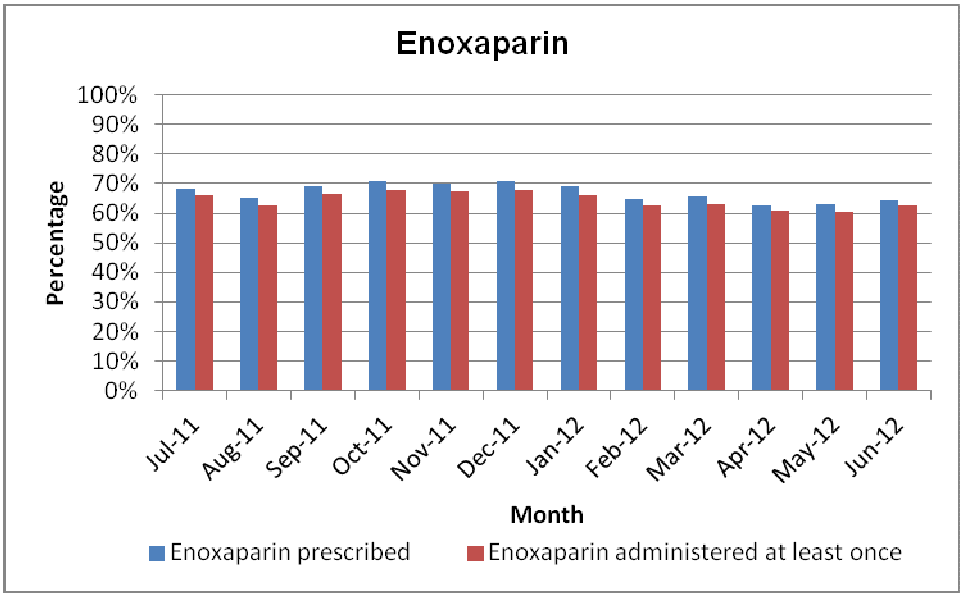
The graph below shows the percentage of graduated elastic compression stockings administered at least once by episode as recorded on the electronic Prescribing and Information Communication System.



One patient admission or spell in hospital can comprise a number of different episodes of care. If the outcome of a VTE risk assessment shows that a patient requires GECS, they are automatically prescribed by PICS. It is not always appropriate to administer compression stockings every day for a variety of reasons including patient choice and clinical contraindications such as sore or swollen skin for example. These two categories account for over two-thirds of the stockings not administered.

VTE Prevention – Enoxaparin Medication

The graph below shows the percentage of patients who required enoxaparin medication following VTE risk assessment and were prescribed it and the percentage who were given it at least once. As with other forms of medication, there can be valid reasons why enoxaparin is not administered such as immediately prior to and after surgery to reduce the risk of bleeding.



Priority 2: Improve patient experience and satisfaction

The Trust measures patient experience and satisfaction in a variety of ways, including local and national patient surveys, complaints and compliments.

Patient Experience Data

Responses to the patient survey remain high with over 5500 responses in quarter 1 2011/12. Responses remain generally very positive and some improvements have been made during quarter 1.

		Performance		
Question	**Answer**	**2011/12**	**Q4 2011/12**	**Q1 2012/13**
1. Have you been involved as much as you want to be in decisions about your care and treatment?	Yes	77.20%	77.80%	**79.36%**
	Yes, to some extent	17.90%	17.90%	**16.60%**
	No	5.00%	4.30%	**4.05%**
2. Did you find someone on the hospital staff to talk about your worries and fears?	Yes, definitely	66.90%	69.60%	**68.15%**
	Yes, to some extent	22.70%	21.10%	**21.99%**
	No	10.30%	9.30%	**9.85%**
3. Were you given enough privacy when discussing your care and treatment?	Yes, always	89.50%	89.70%	**89.61%**
	Yes, sometimes	8.50%	8.30%	**8.24%**
	No	2.00%	2.00%	**2.16%**
4. Do you think that ward staff do all they can to help you rest and sleep at night?*	Yes, definitely	*Data collection started from April 2012*		**77.97%**
	Yes, to some extent			**19.58%**
	No			**2.44%**
5. Do you think that hospital staff do all they can to help control your pain?	Yes, definitely	83.30%	83.20%	**83.39%**
	Yes, to some extent	14.20%	14.40%	**14.25%**
	No	2.50%	2.40%	**2.36%**
6. Have you been bothered by noise at night from hospital staff?	No, never	66.20%	66.10%	**67.90%**
	Yes, occasionally	28.00%	27.80%	**27.05%**
	Yes, often	5.90%	6.00%	**5.05%**
7. Overall how would rate the hospital food you have received?	Excellent	20.30%	21.30%	**20.87%**
	Very good	27.90%	27.60%	**27.67%**
	Good	27.20%	25.90%	**26.21%**
	Fair	16.50%	16.60%	**17.07%**
	Poor	8.10%	8.60%	**8.18%**

8. Sometimes in hospital a member of staff says one thing and another says something quite different. Has this happened to you?	No, never	70.00%	71.90%	**71.91%**
	Yes, sometimes	24.30%	22.10%	**22.44%**
	Yes, often	5.70%	6.00%	**5.65%**
9. Did a member of staff tell you about medication side effects to watch for when you went home?	Yes, completely	46.30%	46.30%	Not enough data*
	Yes, to some extent	9.30%	7.30%	
	No	44.40%	46.30%	
10. Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left hospital?	Yes	72.40%	76.10%	**79.55%**
	No	27.60%	23.90%	**20.45%**

Notes on Patient Experience Data

* The Trust has set a minimum threshold of 30 responses to each question to ensure the data is representative. Responses to the telephone surveys have decreased during the period. A postal survey will be piloted during quarter 2 (July-September) 2012/13 to assess if this method will increase the response rates.

Friends and Family Question (Net Promoter Score)

Trust has started monitoring performance for the new friends and family question known as the Net Promoter Score during quarter 1 2012/13:

- How likely is that you would recommend this service to your friends and family?

This question has been introduced in all acute trusts covered by the Midlands and East Strategic Health Authority (SHA) area. Patients are asked this question from 24 hours before and up to 48 hours after discharge from hospital and can choose from six different responses as follows:

- Extremely likely?
- Likely?
- Neither likely or unlikely?
- Unlikely?
- Not at all?
- Don't know?

Only those patients who pick 'extremely likely' are classed as promoters, 'likely' responses are classed as passive and all the rest are classed as detractors. The Net Promoter Score is calculated by subtracting the detractors from the promoters and then dividing by the number of responses. The passive responses are excluded from the calculation.

The table below shows the Trust's responses and Net Promoter Scores for the period April-June 2012.

Time Period	Promoter	Passive	Detractor	Number of Responses	Patient Discharges	Response Percentage	Net Promoter Score
1-28 April 2012	361	129	43	533	3876	14%	**59.66**
29 April-26 May 2012	282	106	49	437	3945	11%	**53.32**
27 May-30 June 2012	801	255	88	1144	6168	19%	**62.33**

Key actions being taken to improve patient experience include:

- The number of Patient Experience Champions on the wards has increased this quarter and work has commenced to expand the programme to include Outpatient areas.

- The Mystery Shopping programme has been extended to include monitoring of the Trust switchboard, the findings of which are currently being collated and will be fed back to the manager and staff for action. Mystery Shopping visits to the restaurant facilities will take place during quarter 2.

- An electric golf buggy was successfully introduced on 1 April 2012 to transport patients and visitors with mobility difficulties from the car park to the hospital entrance. Over 3650 passengers were transported between the two destinations during quarter 1.

- The Trust is focusing on developing methods of gaining sustainable and regular feedback from outpatients prior to them leaving the department. Various suggestions have been considered and members of the Patient & Carer Council for Outpatients will be involved in choosing the method to be used and choice of questions to be asked.

Complaints

The number of complaints received in the first quarter of 2012/13 was 155, which represents a reduction of 17% compared to quarter 4 (January to March 2012).

	Q4 2011/12	Q1 2012/13
Total number of complaints	186	**155**

Top 3 main subjects of complaints	Q4 2011/12	Q1 2012/13
Clinical treatment	92	**68**
Inpatient appointment delay/cancellation	26	**22**
Communication and information	17	**21**

Ratio of complaints to activity		Q4 2011/12	Q1 2012/13
Inpatients	FCEs*	29,146	**29,610**
	Complaints	109	**92**
	Rate per 100 FCEs	0.37	**0.31**
Outpatients	Appointments**	145,688	**139,178**
	Complaints	56	**42**
	Rate per 100 appointments	0.04	**0.03**
A&E	Attendances	22,465	**23,288**
	Complaints	21	**21**
	Rate per 100 attendances	0.09	**0.09**

* FCE = Finished Consultant Episode – which denotes the time spent by a patient under the continuous care of a consultant.
** Outpatients activity data relates to fulfilled appointments only and also includes Therapies (Physiotherapy, Podiatry, Dietetics, Speech and Language Therapy and Occupational Therapy).

Learning from complaints

The Trust takes a number of steps to review learning from complaints and to take action as necessary. Complaints are reported monthly to the Care Quality Group as part of a wider Patient Experience report. A monthly complaints report is also presented at the Chief Executive's Advisory Group. Each quarter, an analysis of complaints is presented to the Trust's Audit Committee. A more detailed analysis of complaints trends and themes by clinical Division is reported at Divisional Clinical Quality Group meetings. Selected complaints form part of the Executive root cause analysis sessions into omissions in care and, where trends are identified, trust-wide actions are implemented to prevent recurrence.

A Patient Relations Department was created in July 2012, which brought together Complaints and PALS (Patient Advice and Liaison Service) under management structure to ensure closer integration of the services and therefore learning from the contacts received. The work of the Department, including initiatives around learning, will develop over the coming 12 months and beyond.

Independent Reviews

During the first quarter of 2012/13, the Parliamentary and Health Service Ombudsman advised the Trust that two cases had been accepted for initial assessment. A case originally referred to them earlier in the year has now been formally accepted by the Ombudsman for investigation. The Ombudsman has advised that they will not investigate another case previously referred to them. In two other cases, the Trust has been asked to carry out additional local investigation to try and resolve the complaint, without the need for further investigation by the Ombudsman.

Compliments

Compliments are recorded by the Patient Advice and Liaison Service (PALS) on behalf of the Trust. PALS receive some compliments directly from patients and carers; others are forwarded to PALS by staff after being received in wards and departments throughout the Trust.

The majority of compliments are received in writing – by letter, card, email or feedback leaflet, the rest are received verbally via telephone or face to face.

With robust systems now in place for capturing positive feedback, the number of recorded compliments continues to increase. Positive feedback is shared with staff and patients to promote and celebrate good practice as well as to boost staff morale.

Compliment Subcategories	2011/12	Q4 2011/12	Q1 2012/13
Nursing care	605	225	**90**
Friendliness of staff	492	146	**72**
Treatment received	300	80	**55**
Medical care	391	129	**18**
Efficiency of service	124	79	**32**
Information provided	16	3	**2**
Facilities	18	4	**3**
Other	20	8	**8**
Totals:	**1,966**	**674**	**280**

Priority 3: Electronic observation chart – completeness of observation sets (to produce an early warning score)

The Trust started to implement an electronic observation chart during 2010/11 within the Prescribing Information and Communication System (PICS) to record patient observations: temperature, blood pressure, oxygen saturation score, respiratory rate, pulse rate and level of consciousness.

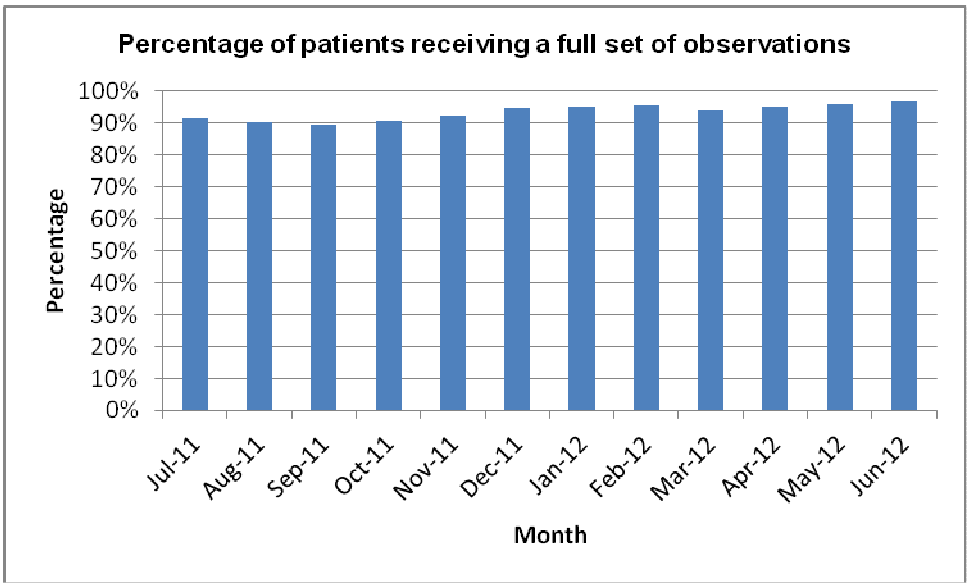
When nursing staff carry out patient observations, it is important that they complete the full set of observations. This is because the electronic tool enables an early warning score called the SEWS (Standardised Early Warning System) score to be triggered automatically if a patient's condition starts to deteriorate. This allows patients to receive appropriate clinical treatment as soon as possible. This indicator measures the percentage of patients who receive at least one full set of observations in a 24-hour period.

The Trust completed the roll out of the electronic observation chart to the remaining wards during 2011/12 so all inpatient wards are now recording patient observations electronically. The four Critical Care areas have very different requirements for recording observations compared to the inpatient wards so do not currently record

these on the standard electronic observation chart in PICS. There is a plan to develop a specific and detailed electronic observation chart for Critical Care in the future.

Performance

The Trust improved performance significantly during 2011/12 with 95.4% of all inpatients receiving at least one full set of observations in March 2012. The Trust is now aiming for at least 98% of all observation sets to be complete for all inpatient wards by the end of 2012/13.



Priority 4: Reducing medication errors (missed doses)

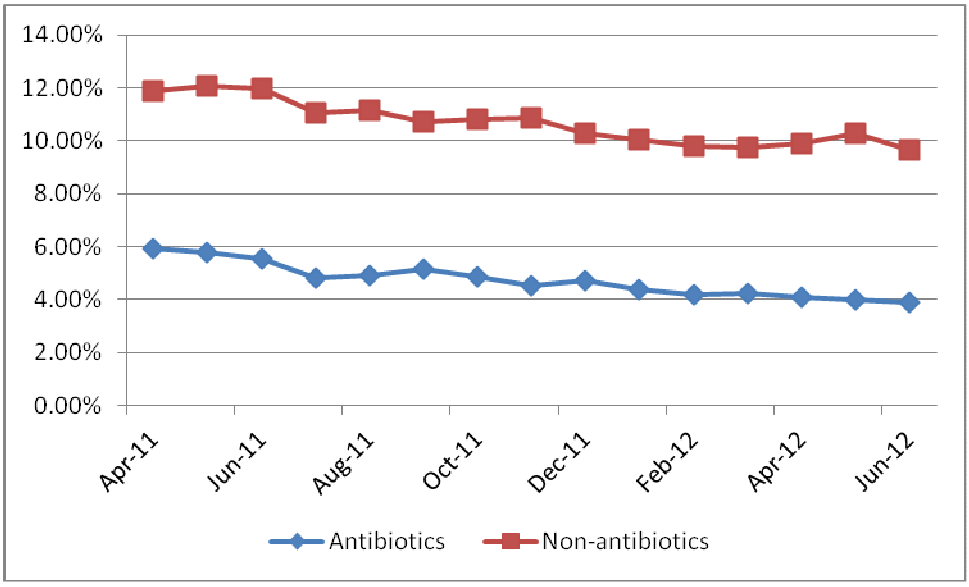
Since April 2009, the Trust has focused on reducing the percentage of drug doses prescribed but not recorded as administered (omitted) to patients on the Prescribing Information and Communication System.

The most significant improvements occurred when the Trust began reporting missed doses data on the Clinical Dashboard in August 2009 and the Executive root cause analysis (RCA) meetings were introduced at the end of March 2010.

Performance

The graphs show that the Trust has made further reductions in the percentage of omitted antibiotic and non-antibiotic drug doses during 2011/12, although the rate of decline has now slowed as expected. UHB is aiming to make further reductions during 2011/12, particularly for non-antibiotics. It is however important to remember that some drug doses are appropriately missed due to the patient's condition at the time. The Trust is therefore evaluating the target reductions in 2011/12 to ensure they are appropriate in the absence of any national agreement on what constitutes an expected level of drug omissions.

The Trust will again be reviewing the reduction targets for antibiotics and non-antibiotics to drive further improvements in 2011/12, with a greater focus on reducing avoidable non-antibiotic missed doses through appropriate prescribing and administration.



Priority 5: Infection prevention and control

In 2012/13, the Trust is working towards further reductions in the incidence of MRSA bacteraemia and toxigenic *Clostridium difficile* infection (CDI) in line with agreed national objectives.

MRSA bacteraemia

The Trust is continuing its focus on reducing the incidence of MRSA bacteraemia though improved management of invasive devices, a programme of education and training and MRSA screening and decolonisation.

The table below shows the Trust's overall performance against trajectory for Quarter 1 2012/13:

	April 2012	**May 2012**	**June 2012**	**Quarter 1 2012/13**	**2012/13**
Actual performance	1	0	0	1	1 (to date)
Agreed trajectory	0.4	0.4	0.4	1.2	5

C. difficile infection

In April, the Trust implemented a two-stage laboratory test for the detection of toxigenic *C. difficile* in line with Department of Health (DH) guidance. This combination of tests is known to be more sensitive and therefore likely to accurately identify a higher number of toxigenic *C. difficile* patients in 2012/13. The Department of Health guidance outlines the requirement for mandatory reporting following the implementation of a two-stage test and the Trust apportioned cases are shown in the table below.

The Trust is continuing to reducing the incidence of CDI infection by focusing on through timely isolation of patients, multidisciplinary patient assessment, appropriate antimicrobial prescribing, hand hygiene, environmental cleaning and education.

The table below shows the Trust's performance against trajectory for Quarter 1 2012/13:

	April 2012	**May 2012**	**June 2012**	**Quarter 1 2012/13**	**2012/13**
Actual performance	7	7	5	19	19 (to date)
Agreed trajectory	6.3	6.3	6.3	18.9	76

The Trust has continued to report meticillin-sensitive *Staphylococcus aureus* (MSSA) and *Escherichia coli* (*E. coli*) bacteraemia during Quarter 1 2012/13 to the Health Protection Agency as part of the mandatory surveillance requirements. Improvement objectives have not been set for these organisms and these data will contribute to establishing a baseline.

4. Performance of the Trust against selected metrics

The tables below show the Trust's latest performance for 2012/13 and the last two financial years for a selection of indicators for patient safety, clinical effectiveness and patient experience.

The patient safety and clinical effectiveness indicators were originally selected by the Clinical Quality Monitoring Group because they represent a balanced picture of quality at UHB. The patient experience indicators were selected in consultation with the Care Quality Group which has Governor representation to enable comparison with other NHS trusts.

The latest available data for 2012/13 is shown below and has been subject to the Trust's usual data quality checks by the Health Informatics team. Benchmarking data has also been included where possible. Performance is monitored and challenged during the year by the Clinical Quality Monitoring Group and the Board of Directors.

Patient safety indicators

Indicator	2010/11	2011/12	2012/13	Peer Group Average (where available)
1(a). MRSA: Patients with MRSA infection/10,000 bed days (includes all bed days from all specialties) *Lower rate indicates better performance*	**0.33**	**0.15**	***Not yet available***	***Not yet available***
Time period	2010/11	2011/12		
Data source	Trust MRSA data reported to HPA, HES data (bed days)	Trust MRSA data reported to HPA, HES data (bed days)	Trust MRSA data reported to HPA, HES data (bed days)	Trust MRSA data reported to HPA, HES data (bed days)
Peer group				Acute trusts in West Midlands SHA

Indicator	2010/11	2011/12	2012/13	Peer Group Average (where available)
1(b). MRSA: Patients with MRSA infection/10,000 bed days (aged >15, excluding Obstetrics Gynaecology and elective Orthopaedics) *Lower rate indicates better performance*	**0.33**	**0.15**	***Not yet available***	***Not yet available***
Time period	2010/11	2011/12		
Data source	Trust MRSA data reported to HPA, HES data (bed days)	Trust MRSA data reported to HPA, HES data (bed days)	Trust MRSA data reported to HPA, HES data (bed days)	Trust MRSA data reported to HPA, HES data (bed days)
Peer group				Acute trusts in West Midlands SHA
2(a). *C. difficile:* Patients with *C. difficile* infection/1,000 bed days (includes all bed days from all specialties) *Lower rate indicates better performance*	**43.33**	**25.43**	***Not yet available***	***Not yet available***
Time period	2010/11	2011/12		
Data source	Trust CDI data reported to HPA, HES data (bed days)	Trust CDI data reported to HPA, HES data (bed days)	Trust CDI data reported to HPA, HES data (bed days)	Trust CDI data reported to HPA, HES data (bed days)
Peer group				Acute trusts in West Midlands SHA

Indicator	2010/11	2011/12	2012/13	Peer Group Average (where available)
2(b). *C. difficile:* Patients with *C. difficile* infection/1,000 bed days (aged >15, excluding Obstetrics Gynaecology and elective Orthopaedics) *Lower rate indicates better performance*	**43.34**	**25.43**	***Not yet available***	***Not yet available***
Time period	2010/11	2011/12		
Data source	Trust CDI data reported to HPA, HES data (bed days)	Trust CDI data reported to HPA, HES data (bed days)	Trust CDI data reported to HPA, HES data (bed days)	Trust CDI data reported to HPA, HES data (bed days)
Peer group				Acute trusts in West Midlands SHA
3(a) Patient safety incidents (reporting rate per 100 admissions) *Higher rate indicates better reporting*	**9.1**	**9.3**	**10.4**	*Not yet available*
Time period	2010/11	2011/12	April–June 2012	April–June 2012
Data source	Datix (incident data), Trust admissions data	Datix (incident data), Trust admissions data	Datix (incident data), Trust admissions data	
Peer group				

Indicator	2010/11	2011/12	2012/13	Peer Group Average (where available)
3(b) Never Events *Lower number indicates better performance*	**2**	**1** (see explanatory note below table)	**0**	*Not available*
Time period	2010/11	2011/12	April-June 2012	
Data source	Datix (incident data)	Datix (incident data)	Datix (incident data)	
Peer Group				
4(a) Percentage of patient safety incidents which are no harm incidents *Higher % indicates better performance*	**81.3%**	**70.4%**	**64.4%**	*Not yet published*
Time period	2010/11	2011/12	April-June 2012	April-June 2012
Data source	Datix (incident data)	Datix (incident data)	Datix (incident data)	
Peer group				
4(b) Percentage of patient safety incidents resulting in severe harm or death *Lower % indicates better performance*	*Not available*	**1.4%**	**1.7%**	*Not yet available*
Time period		2011/12	2011/12	
Data source		Datix (incident data)	Datix (incident data)	
Peer group				

Notes on patient safety indicators

1(a), 1(b), 2(a), 2(b): The data for *C.difficile* infection has been calculated using 100,000 bed days rather than 1,000 used previously, in line with DH guidance.

3(a): The admissions data has been changed to include dialysis patients from Q1 2012/13 as these are also classed as admissions. The data for 2010/11 and 2011/12 has been recalculated to aid comparison and therefore differs from that shown in the Trust's 2011/12 Quality Account.

3(b): The Trust reported one never event during 2011/12. The incident was recorded as 'retained foreign object post-operation' and related to a swab being left inside a patient during surgery at the Queen Elizabeth Hospital Birmingham. The swab was subsequently removed and the patient suffered no ill-effects as a result.

4(a): The reduction in the percentage of no harm incidents in 2010/11, 2011/12 and Q1 2012/13 is largely due to the reporting of all grades of pressure ulcer as harm incidents from April 2010 and a reduction in the number of (no harm) incidents relating to missing medical records following the introduction of the electronic Clinical Portal in Outpatients.

4(b): There were no patient safety incidents which resulted in death reported during 2011/12. There were 2 deaths following falls reported in quarter 1 2012/13 which have been fully investigated in line with the Trust's procedure for Serious Incidents Requiring Investigation (SIRIs).

Clinical effectiveness indicators

Indicator	2010/11	2011/12	2012/13	Peer Group Average (where available)
5(a). Readmissions: Readmission rate (Medical and surgical specialties - elective and emergency admissions aged >15) % *Lower % indicates better performance*	**6.22%**	**5.34%**	***Not yet available***	***Not yet available***
Time period	2010/11	2011/12		
Data source	HES data	HES data		
Peer group				

Indicator	2010/11	2011/12	2012/13	Peer Group Average (where available)
5(b). Readmissions: Readmission rate (all specialties) % *Lower % indicates better performance*	**6.20%**	**5.33%**	***Not yet available***	***Not yet available***
Time period	2010/11	2011/12		
Data source	HES data	HES data		
Peer group				
6. Falls (incidents reported as % of elective and emergency admissions) *Lower % indicates better performance*	**2.1%**	**2.2%**	**2.1%**	*Not available*
Time period	2010/11	2011/12	April-June 2012	
Data source	Datix (incident data), Trust admissions data	Datix (incident data), Trust admissions data	Datix (incident data), Trust admissions data	

Indicator	2010/11	2011/12	2012/13	Peer Group Average (where available)
7. Percentage of stroke patients (infarction) on aspirin, clopidogrel or warfarin *Higher % indicates better performance*	**100%**	**100%**	**100%**	*Not available*
Time period	2010/11	2011/12	April-June 2012	
Data source	Trust PICS data	Trust PICS data	Trust PICS data	
Peer group				
8. Percentage of beta blockers given on the morning of the procedure for patients undergoing first time coronary artery bypass graft (CABG) *Higher % indicates better performance*	**92.6%**	**93.6%**	**100%**	*Not available*
Time period	2010/11	2011/12	April-May 2012	
Data source	Trust PICS data	Trust PICS data	Trust PICS data	
Peer group				

Notes on clinical effectiveness indicators

The data shown is subject to standard national definitions where appropriate. The Trust has also chosen to include infection and readmissions data which has been corrected to reflect specialty activity, taking into account that the Trust does not undertake paediatric, obstetric, gynaecology or elective orthopaedic activity. These specialties are known to be very low risk in terms of hospital acquired infection for example and therefore excluding them from the denominator (bed day) data enables a more accurate comparison to be made with peers.

5(a), 5(b): The data shown relates to patients who are readmitted within 30 days of being discharged from UHB to any provider in England, including private sector providers. In line with guidance from the Department of Health, the new methodology also includes patients who were originally admitted as daycases (for a planned procedure) and regular daycases (e.g., patients attending dialysis):
http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_125490.pdf The data is now presented for 100,000 bed days rather than 1,000 bed days.

6: The admissions data includes daycase patients as well as all elective and emergency admissions. The admissions data now also includes dialysis patients from Q1 2012/13 as these are also classed as admissions. The data for 2010/11 and 2011/12 has been recalculated to aid comparison and therefore differs from that shown in the Trust's 2011/12 Quality Account.

7: Aspirin, clopidogrel or warfarin are given to reduce the likelihood of recurrent stroke or transient ischaemic attack (TIA) in patients who have already suffered a stroke. Any patients who are identified as not having been given aspirin, clopidogrel or warfarin during their stay are followed up to ensure they have been discharged on these drugs if clinically appropriate.

8: Beta blockers are given to reduce the likelihood of peri-operative myocardial infarction and early mortality. This indicator relates to patients already on beta blockers and whether they are given beta blockers on the day of their operation. All incidences of beta blockers not being given on the day of operation are investigated to understand the reasons why and to reduce the likelihood of future omissions.